DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 — 1 9

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 96 $ (500,000)
b. FFY 97 $ (1,500,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attached

10. SUBJECT OF AMENDMENT:

Nursing Facility Methods and Standards for Establishing Payment Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:
12-26-95

16. RETURN TO:
Janet Schalansky, Deputy Secretary
Kansas Dept. of Social and Rehabilitation Service
Docking State Office Building
915 Harrison, 6th Floor
Topeka, Kansas 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
01/08/96

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/95

20. SIGNATURE OF REGIONAL OFFICIAL:
Thomas W. Lenz

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:

cc:
Schalansky
Haverkamp
CO

SPA CONTROL

Date Submitted 12/26/95
Date Received 01/08/96

FORM HCFA-179 (07-92)

Instructions on Back

KANSAS MEDICAID STATE PLAN

Form HCFA-179
State Plan MS-95-19
Attachment 4.19D, Part I
Nursing Facility

Number of Plan Section:	Number of Superseded Plan Section:
Assurance Letter Dated December, 1995	Assurance Letter Date September, 27, 1995, TN-MS-95-15
Subpart A:	Subpart A:
Exhibit A-1, pages 1-11	Exhibit A-1, pages 1-10, TN-MS-94-21
Exhibit A-3, pages 1-7	Exhibit A-3, pages 1-6, TN-MS-94-02
Exhibit A-5, pages 1-38	Exhibit A-5, pages 1-39, TN-MS-94-02
Exhibit A-6, pages 1-9	Exhibit A-6, pages 1-9, TN-MS-94-21
Exhibit A-7, pages 1-2	Exhibit A-7, pages 1-2, TN-MS-94-02
Exhibit A-10, pages 1-4	Exhibit A-10, pages 1-3, TN-MS-94-02
Exhibit A-11, pages 1-4	Exhibit A-11, pages 1-3, TN-MS-92-32
Exhibit A-13, pages 1-5	Exhibit A-13, pages 1-5, TN-MS-92-32
Exhibit A-14, pages 1-5	Exhibit A-14, pages 1-5, TN-MS-94-02
Exhibit A-16, pages 1-3	Exhibit A-16, pages 1-3, TN-MS-92-32
Exhibit A-18, pages 1-3	Exhibit A-18, pages 1-3, TN-MS-92-32
Exhibit C-1, pages 1-12	Exhibit C-1, pages 1-6 and 8-11, TN-MS-94-17 and page 7, TN-MS-95-15

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

December 26, 1995

Mr. Richard P. Brummel
Associate Regional Administrator for the
Division of Medicaid
Room 235, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs-Mental Health (MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(b) Findings

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

42 CFR 447.253(b)(1)(i) Payment Rates

The State of Kansas continues to pay NFs and NFs-MH for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(iii) Payment Rates

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-95-19

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour basis;

(C) The State of Kansas established procedures under which the data and methodology used in establishing payment rates are made available to the public.

42 CFR 447.253(b)(2) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment is reasonably expected to pay no more in the aggregate for NF and NF-MH services than the amount the agency reasonably estimates would be paid under the Medicare principles of reimbursement. There are no state operated NFs or NFs-MH so 447.272(b) does not apply.

42 CFR 447.253(d) Changes in Ownership of NFs and ICFs-MR

The State of Kansas assures that its NFs and NFs-MH payment methodology is not reasonably expected to result in an increase in aggregate payments based solely as the result of a change in ownership in excess of the increase that would result from application of 447.253(d)(1) and (2).

42 CFR 447.253(e) Provider Appeals

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 CFR 447.253(f) Uniform Cost Reporting

Nursing facility and NF-MH providers are required to file annual uniform cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part I, Methods and Standards for Establishing Payment Rates.

42 CFR 447.253(g) Audit Requirements

The State of Kansas performs a review on all cost reports within six months of receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

42 CFR 447.253(h) Public Notice

In accordance with 42 CFR 447.205, public notice is given for the significant changes proposed to the methods and standards for setting NF and NF-MH payment rates.

Refers to MS-95-19

42 CFR 447.253(i) Rates Paid

The State of Kansas assures that payment rates are determined in accordance with methods and standards specified in an approved State Plan.

42 CFR 447.255 Related Information

Estimated Average NF/NF-MH Rate:	10/1/95	$63.68
Estimated Average NF/NF-MH Rate:	7/1/95	$63.68
Per Diem Increase		0
Average Percent Increase		0%

Both the short-term and long-term effect of these changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.

   There are approximately 406 licensed NFs or NFs-MH in the State of Kansas with at least one in every county. Of these, 399 or 98% are certified to participate in the Medicaid Program. There are 15 licensed NFs-MH in the State of Kansas and all of them participate in the Medicaid program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and

3. Maintain the extent of provider participation.

   The extent of provider participation should not be affected by this change. Ninety-eight percent of the available providers are already participating in the program.

Any questions regarding this Plan submission should be directed to Tina Hayes or Bill McDaniel at (913) 296-3981.

Sincerely,

Janet Schalansky
Deputy Secretary

JS:AEK:mas

Refers to MS-95-19

30-10-1a (1)

30-10-1a. Nursing facility program definitions. (a) The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise.

(1) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active treatment for individuals with mental retardation or related condition" means a continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed towards:

(A) the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(3) "Agency" means the department of social and rehabilitation services.

(4) "Ancillary services and other medically necessary services" means those special services or supplies, in addition to routine servies, for which charges are made .

(5) "Case mix" means a measure of the intensity of care and services used by a group of residents in a facility.

30-10-1a (2)

(6) "Case mix index" means a numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.

(7) "Change of ownership" means a transfer of rights and interests in real and personal property used for nursing facility services through an arms-length transaction between unrelated persons or legal entities.

(8) "Change of provider" means a change of ownership or lessee specified in the provider agreement.

(9) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility and in the company engaged in business with the provider facility.

(10) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(11) "Cost and other accounting information" means adequate data, including source documentation, that is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash pay out memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, the provider shall

30-10-1a (3)

maintain financial and statistical records in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(12) "Cost finding" means recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(13) "Costs not related to resident care" means costs which are not appropriate, necessary or proper in developing and maintaining the nursing facility operation and activities. These costs are not allowable in computing reimbursable costs.

(14) "Costs related to resident care" means all necessary and proper costs, arising from arms-length transactions in accordance with general accounting rules, which are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27 and K.A.R. 30-10-28.

(15) "Cost report" means the nursing facility financial and statistical report.

(16) "Educational activities" means an approved, formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in an institution. These activities shall be licensed when required by state law.

30-10-1a (4)

(17) "Educational activities--net cost" means the cost of approved educational activities less any grants, specific donations or reimbursements of tuition.

(18) "Hospital-based nursing facility" means a nursing facility as defined in K.A.R. 30-10-1a that is attached to or associated with a hospital.

(19) "Inadequate care" means any act or failure to act which may be physically or emotionally harmful to a recipient.

(20) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function. Relevant diagnoses shall be limited to schizophrenia, major affective disorders, atypical psychosis, bipolar disorder, paranoid disorders or schizoaffective disorder.

(21) "Mental retardation" means subaverage general intellectual functioning which originates in the developmental period and which is associated with an impairment in adaptive behavior.

(22) "Non-working owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(23) "Non-working related party or director" means any related party as defined in K.A.R. 30-10-1a who does not perform a resident-related function for the nursing facility.

30-10-1a (5)

(24) "Nursing facility (NF)" means a facility which meets state licensure standards and which provides health-related care and services, prescribed by a physician, to residents who require 24- hours- per-day, seven- days per-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(25) "Nursing facility for mental health" means a nursing facility which meets state licensure standards and provides structured mental health rehabilitation services, in addition to health-related care, for individuals with a severe and persistent mental illness who require 24-hours-per-day, seven-days-per-week, licensed nursing supervision. The nursing facility shall have been operating in accordance with a provider agreement with social and rehabilitation services on June 30, 1994.

(26) a providers designation as an "on-going entity" means a change in the provider has not been recognized.

(27) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of legal business entity. These costs shall be considered to be intangible assets representing expenditures for rights and privileges which have value to the business.

(28) "Owner-related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a five percent or greater interest in the provider or any related party as defined in K.A.R. 30-10-1a, whether the payment

is from a sole proprietorship, partnership, corporation, or non-profit organization.

(29) " Owner" means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(30) "Plan of care for nursing facilities" means a document which states the need for care, the estimated length of the program, the methodology to be used, and the expected results.

(31) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report shall be based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(32) "Provider" means the operator of the nursing facility specified in the provider agreement.

(33) "Recipient" means a person determined to be eligible for medicaid/medikan services in a nursing facility.

(34) "Related parties" refers to any relationship between two or more parties in which one party has the ability to influence another party to the transaction in the following manner:

(A) one or more of the transacting parties might fail to pursue the parties' own separate interests fully;

30-10-1a (7)

(B) the transaction is designed to inflate medicaid/medikan costs. Related parties shall include parties related by family, business or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arms-length negotiations ; or

(C) any party considered a related party to a previous owner or operator, becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator.

(35) "Related to the nursing facility" means that the facility is significantly associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(36) "Representative" means either of the following:

(A) a legal guardian, conservator or representative payee as designated by the social security administration; or

(B) any person designated in writing by the resident to manage the resident's personal funds, and who is willing to accept the designation.

(37) "Resident assessment form" means the document which:

(A) is jointly specified by the Kansas department of health and environment and the agency;

(B) is approved by the health care finance administration; and

(C) includes the minimum data set.

(38) "Resident day" means that period of service rendered to a patient or resident between census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any medicaid/medikan or non-medicaid/medikan resident who was not in the home. Census-taking hours shall consist of 24 hours beginning at midnight.

(39) "Routine services and supplies" means services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies shall be included in the provider's cost report.

(40) "Sale-leaseback" is a transaction where an owner sells a facility to a related or non-related purchaser and then leases the facility from the new owner to operate as the provider.

(41) "Severe and persistent mental illness" means that an individual:

(A) meets one of the following criteria:

(i) the individual has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime;

(ii) the individual has experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least two months; and

(B) meets at least two of the following criteria, on a continuing or intermittent basis, for at least two years:

(i) the individual is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) the individual requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help;

(iii) the individual shows severe inability to establish or maintain a personal social support system;

(iv) the individual requires help in basic living skills; or

(v) the individual exhibits inappropriate social behavior which results in a need for intervention by the mental health or judicial system.

(42) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services which provides ongoing treatment for mental health problems aimed at attaining or maintaining the highest level of mental and psychosocial well-being. The specialized rehabilitative services include the following:

(A) crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and

withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(43) "Specialized services" means inpatient psychiatric care for the treatment of an acute episode of mental illness.

(44) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital bed or nursing facility bed .

(45) "Twenty-four hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(46)"Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report.

(b) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended

30-10-1a (11)

Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995.)

30-10-15a (1)

30-10-15a. Reimbursement. Payment for services. (a) Providers with a current signed provider agreement shall be paid a per diem rate for services furnished to medicaid/medikan eligible residents. Payment shall be for the type of medical or health care required by the beneficiary as determined by the attending physician's or physician extender's certification upon admission. However, payment for services shall not exceed the type of care the provider is certified to provide under the medicaid/medikan program. The type of care required by the beneficiary may be verified by the agency before and after payment.

(b) Payment for routine services and supplies, pursuant to K.A.R. 30-10-1a, shall be included in the per diem reimbursement and such services and supplies shall not be otherwise billed or reimbursed.

(1) The following durable medical equipment, medical supplies and other items and services shall be considered routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the comprehensive assessment and plan of care and shall not be billed or reimbursed separately from the per diem rate:

(A) Alternating pressure pads and pumps;

(B) armboards;

(C) bedpans, urinals and basins;

30-10-15a (2)

(D) bed rails, beds, mattresses and mattress covers;

(E) canes;

(F) commodes;

(G) crutches;

(H) denture cups;

(I) dialysis, including supplies and maintenance;

(J) dressing items, including applicators, tongue blades, tape, gauze, bandages, band-aids, pads and compresses, ace bandages, vaseline gauze, cotton balls, slings, triangle bandages, pressure pads and tracheostomy care kits;

(K) emesis basins and bath basins;

(L) enemas and enema equipment;

(M) facial tissues and toilet paper;

(N) footboards;

(O) footcradles;

(P) gel pads or cushions;

(Q) geri-chairs;

(R) gloves, rubber or plastic;

(S) heating pads;

(T) heat lamps and examination lights;

30-10-15a (3)

(U) humidifiers;

(V) ice bags and hot water bottles;

(W) intermittent positive pressure breathing (IPPB) machines;

(X) I.V. stands and clamps;

(Y) laundry, including personal laundry;

(Z) lifts;

(AA) nebulizers;

(BB) occupational therapy;

(CC) oxygen masks, stands, tubing, regulators, hoses, catheters, cannulae and humidifiers;

(DD) parenteral and enteral infusion pumps;

(EE) patient gowns, pajamas and bed linens;

(FF) physical therapy;

(GG) restraints;

(HH) sheepskins and foam pads;

(II) speech therapy;

(JJ) sphygmomanometers, stethoscopes and other examination equipment;

(KK) stretchers;

(LL) suction pumps and tubing;

(MM) syringes and needles, except insulin syringes and needles for diabetics that are covered by the pharmacy program;

(NN) thermometers;

(OO) traction apparatus and equipment;

(PP) underpads and adult diapers, disposable and non-disposable;

(QQ) walkers;

(RR) water pitchers, glasses and straws;

(SS) weighing scales;

(TT) wheelchairs;

(UU) irrigation solution, both water and normal saline;

(VV) lotions, creams and powders, including baby lotion, oil and powders;

(WW) first-aid type ointments;

(XX) skin antiseptics such as alcohol;

(YY) antacids;

(ZZ) mouthwash;

(AAA) over-the-counter analgesics;

(BBB) laxatives;

(CCC) stool softeners;

(DDD) nutritional supplements;

(EEE) blood glucose monitors and supplies;

(FFF) extra nursing care and supplies;

(GGG) compressors;

(HHH) orthoses and splints to prevent or correct contractures;

(III) maintenance care for residents, who have head injuries ;

(JJJ) non-emergency transportation; and

(KKK) respiratory therapy.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the medicaid/medikan program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed in the per diem rate of the cost report.

(3) Nutritional therapy. In order to qualify for reimbursement, total nutritional replacement therapy shall require prior authorization.

(4) Medications not covered by the medicaid pharmacy program, over-the-counter drugs/supplies and/or personal comfort items which are regularly available without prescription at a commercial pharmacy or medical supply outlet and which may be stocked by the facility shall be routine.

(5) For medicare-certified facilities, medical services or a designee shall adjust the

cost of occupational, physical, respiratory and speech therapy by both the ratio of medicaid units of service to total units of service and the ratio of total resident days to medicaid days. The facility shall report the total expense on the cost report and the total of medicaid units of service in an attachment. Medical services or a designee shall calculate the adjustment if the provider does not provide the required information, the medicare revenue shall be offset against the expense, but not below zero.

(c) Providers of ancillary services, as defined in K.A.R. 30-10-1a, shall bill separately for the services when the services or supplies are required. Payment for oxygen shall be reimbursed to the oxygen supplier through the agency's fiscal agent, or the fiscal agent may reimburse the nursing facility directly if an oxygen supplier is unavailable.

(d) Payment for specialized rehabilitative services or active treatment programs shall be included in the per diem reimbursement.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the medicaid/medikan program.

(f) Payment shall not be made for allowable non-routine services and items unless the provider has obtained prior authorization .

(g) Private rooms for recipients shall be covered when medically necessary or at the discretion of the facility, and the costs shall be reflected in the facility's cost report. If a

30-10-15a (7)

private room is not medically necessary or is not occupied at the discretion of the facility, a family member, guardian, conservator or other third party may pay the difference between the usual and customary charge and the medicaid payment rate.

(h) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995.)

30-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the nursing facility financial and statistical report in accordance with the December 1995 version of the "instructions for completing the nursing facility financial and statistical report (MS-2004)", which is hereby adopted by reference.

(2) Each provider who has operated a facility for 12 or more months as of December 31st shall file the nursing facility financial and statistical report on a calendar year basis.

(3) Each provider who has operated a facility on cost data from the previous provider or a projected cost report shall file an historical cost report.

(A) The historical cost report shall begin on the first day of the month closest to the date the new provider or facility is certified by the department of health and environment.

(B) The historical cost report shall end on the last day of the 12-month period following the date specified in paragraph (A), except:

(i) The cost report shall end on December 31st when that date is not more than one month before or after the end of the 12-month period;

(ii) the cost report shall end on the provider's normal fiscal year end used for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria for filing the cost report ending on December